TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

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3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
TITLE XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 8, 1995

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447

7. FEDERAL BUDGET IMPACT:
a. FFY 95 $ 2,741,022
b. FFY Future $ between $3M and 7.5M

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A, pages 30 and 31.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SAME

10. SUBJECT OF AMENDMENT:
Acute Inpatient Payment System

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not Required under 42 CFR 430.12(b)(2)(i)

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Bruce M. Bullen

13. TYPED NAME:
Bruce M. Bullen

14. TITLE:
Commissioner, Division of Medical Assistance

15. DATE SUBMITTED:
6/30/95

16. RETURN TO:
Bridget Landers
Coordinator for State Plan
Division of Medical Assistance
600 Washington Street, 3rd Floor
Boston, MA 02111

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: June 30, 1995

18. DATE APPROVED: May 11, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
April 8, 1995

20. SIGNATURE OF REGIONAL OFFICIAL:
Dennis M. Dolomisio for

21. TYPED NAME:
Ronald P. Preston

22. TITLE:
Associate Regional Administrator, DMSO

23. REMARKS:

OFFICIAL

JUN 30 95

BOSTON-HCFA-DMAD
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FORM HCFA-179 (07-92)

Instructions on Back

*(attached as **Exhibit 4**). For purposes of this classification only, the term "disproportionate share hospital" refers to any acute hospital that exhibits a payor mix where a minimum of sixty-three percent of the acute hospital's gross patient service revenue is attributable to Title XVIII and Title XIX of the Federal Social Security Act, other government payors and free care. Payments shall be made during the term of the RY95 hospital contract.*

2. ***Basic Federally-Mandated Disproportionate Share Adjustment***
(Total Funding: $200,000)

*The eligibility criteria and payment formula for this DSH classification are described in regulations of the Rate Setting Commission at 114.1 CMR 36.13(10)(b) (attached as **Exhibit 4**) and in accordance with the minimum requirements of 42 U.S.C. §1396r-4. Payments will be made to qualifying hospitals by the Division during the term of the RY95 hospital contract.*

3. ***Disproportionate Share Adjustment for Safety Net Providers***

A disproportionate share safety net adjustment factor for all eligible hospitals shall be determined.

This class of hospital was identified and included to ensure that those hospitals which provide the services most critical to the poor are reimbursed for their overload of free care so that they can continue to provide the services which we deem crucial to the provision of adequate health care.

a. Determination of Eligibility

The disproportionate share adjustment for safety net providers is an additional payment for all hospitals eligible for the basic federally-mandated disproportionate share adjustment pursuant to Section IV.2.C.2, above, which also meet the following additional criteria:

i. is a public hospital;
ii. has a volume of free care charges in FY93 which is at least 15% of total charges;
iii.. is an essential safety net provider in its service area, as demonstrated by delivery of services to populations with special needs, including persons with AIDS, trauma victims, high-risk neonates, and indigent patients without access to other providers;
iv. has completed an agreement with the Division of Medical Assistance for the federally-mandated disproportionate share adjustment for safety net providers.

b. Payment Methodology

An additional adjustment shall be calculated for federally-mandated disproportionate

share hospitals which are eligible for the safety net provider adjustment.

i. *This payment amount shall be reasonably related to the costs of services provided to patient eligible for medical assistance under Title XIX, or to low-income patients.*

ii. *This payment adjustment shall be based on an agreement between the Department and the qualifying hospital. The Department shall make a disproportionate share payment adjustment to the qualifying hospital; provided that such payment shall be adjusted if necessary, to ensure that a qualifying hospital's total disproportionate share adjustment payments for a fiscal year under the State Plan do not exceed (a) for periods prior to July 1, 1995, 180% of such hospital's total unreimbursed free care and unreimbursed Medicaid costs; and (b) for periods on or after July 1, 1995, 100% of such hospital's total unreimbursed free care and unreimbursed Medicaid costs for the same fiscal year. Such unreimbursed costs shall be calculated by the Division using the best data available, as determined by the Division, for the fiscal year.*

iii. *The payment of the safety net adjustment to a qualifying hospital in any rate year shall be contingent upon the continued availability of federal financial participation for such payments.*

4. *Uncompensated Care Disproportionate Share Adjustment*

Hospitals eligible for this adjustment are those acute facilities that incur "free care costs" as defined in regulations of the Department of Medical Security (DMS) at 117 CMR 7.00 (attached as Exhibit 6). The payment amounts for eligible hospitals participating in the free care pool are determined and paid by the Department of Medical Security in accordance with its regulations at 117 CMR 7. Eligible hospitals will receive these payments on a periodic basis during the term of their RY95 Medicaid contract with the Division.

To qualify for a DSH payment adjustment under any classification within Section IV.2.C, a hospital must meet the obstetrical staffing requirements described in Title XIX at 42 U.S.C. §1396r-4(d) or qualify for the exemption described at 42 U.S.C. §1396r-4(d)(2).

D. ***Treatment of Reimbursement for Recipients in the Hospital on the Effective Date of the Hospital Contract***

Reimbursement to participating hospitals for services provided to Medicaid recipients who are at acute inpatient status prior to October 1, 1994 and who remain at acute inpatient status on October

Exhibits To Inpatient State Plan TN 95-10

Exhibit 4:	114.1 CMR 36.13(10), Rate Setting Commission Regulations
Exhibit 5:	117 CMR 7.00, Department of Medical Security Regulations
Exhibit 7:	MGL c6B §1, Acute Hospital Finance, Definitions
Exhibit 8:	MGL c6B §2(b), Determination for Rates of Payment to Acute Hospitals for Title XIX Services

Exhibit 4 To Inpatient State Plan

Rate Setting Commission Regulations

114.1 CMR 36.13(10)

36.13: continued

(d) Rates of payment for emergency services provided by ambulance services are established according to the methodology set forth in 114.1 CMR 36.13(8)(g).
(e) Rates of payment for emergency dialysis services are established according to the methodology set forth in 114.1 CMR 36.13(8)(h).
(f) Rates of payment for emergency psychiatric day treatment are established according to the methodology set forth in 114.1 CMR 36.13(8)(i).
(g) Rates of payment for emergency dental services are established according to the methodology set forth in 114.1 CMR 36.13(8)(j).
(h) Payment for emergency inpatient admissions is made using the transfer per diem rate of payment, established according to the methodology set forth in 114.1 CMR 36.13 S.(4), up to the hospital-specific standard payment amount per discharge, established according to the methodology set forth in 114.1 CMR 36.13(2). Hospitals must notify the Division of Medical Assistance within 24 hours of admitting a Medicaid beneficiary in order to be eligible for payment pursuant to 114.1 CMR 36.13(9).

(10) Classifications of Disproportionate Share Hospitals (DSHs) and Payment Adjustments. The Medicaid program will assist hospitals who carry a disproportionate financial burden of caring for the uninsured and low income persons of the Commonwealth. In accordance with Title XIX rules and requirements, Medicaid will make an additional payment adjustment above the rates established under 114.1 CMR 36.13(10) to hospitals which qualify for such an adjustment under any one or more of the following classifications. Medicaid participating hospitals may qualify for adjustments and may receive them at any time throughout the year. Eligibility requirements for each type of disproportionate share adjustment and the methodology for calculating those adjustments is described below. Medicaid payment adjustments for disproportionate share contribute toward funding of allowable uncompensated care costs.

When hospitals apply to participate in the Medicaid program, their eligibility and the amount of their adjustment shall be determined. As new hospitals apply to become Medicaid providers, they may qualify for adjustments if they meet the criteria under one or more of the following DSH classifications (114.1 CMR 36.13(10)(a) through (e). If a hospital's Medicaid contract is terminated, any adjustment will be prorated for the portion of the year during which it had a contract, the remaining funds it would have received will be apportioned to remaining eligible hospitals. This means that some disproportionate share adjustments may require recalculation. Hospitals will be informed if an adjustment amount should change due to reapportionment among the qualified group and will be told how overpayments or underpayments by the Division will be handled at that time.

To qualify for a DSH payment adjustment under any classification within 114.1 CMR 36.13(10), a hospital must meet the obstetrical staffing requirements described in Title XIX at 42 U.S.C. § 1396r-4(d) or qualify for the exemption described at 42 U.S.C. § 1396r-4(d)(2).

(a) High Public Payer Hospitals: Disproportionate Share Status under C.495.

1. Eligibility. Hospitals determined eligible for disproportionate share status pursuant to 114.1 CMR 36.10 are eligible for this adjustment.

2. Calculation of Adjustment.

a. The Division of Medical Assistance will allocate $11.7 million for this payment adjustment.

b. The Commission will then calculate for all acute care hospitals the ratio of their allowable free care charges, as defined in M.G.L. c. 118F, § 2, to total charges, for the period October 1, 1991 through September 30, 1992. The Commission will obtain allowable free care charge data from the Department of Medical Security.

c. The Commission will then calculate the statewide average of the ratios of allowable free care to total charges determined in 114.1 CMR 36.13(10)(a)2.b.

d. The Commission will then determine the higher of (i) the ratio determined in 114.1 CMR 36.13(10)(a)2.b. minus the mean calculated in 114.1 CMR 36.13(10)(a)2.c.; or (ii) zero.

36.13: continued

e. Hospitals for whom the amount determined in 114.1 CMR 36.13(10)(a)2.d. is greater than zero qualify for a High Public Payer Hospitals adjustment. The Commission will multiply each qualifying hospital's FY92 allowable free care charges by the hospital's most current cost to charge ratio as of October 1, 1993, as calculated pursuant to 114.1 CMR 36.09 to determine allowable free care costs.

f. The Commission will then determine the sum of the amounts determined in 114.1 CMR 36.13(a)2.e. for all hospitals that qualify for a High Public Payer Hospitals adjustment.

g. Each hospital's FY94 High Public Payer Hospitals adjustment is equal to the amount specified in 114.1 CMR 36.13(10)(a)2.a. multiplied by the amount determined in 114.1 CMR 36.13(10)(a)2.e. and divided by the amount determined in 114.1 CMR 36.13(10)(a)2.f.

(b) Basic Federally - Mandated Disproportionate Share Adjustment.

1. The Commission will determine a federally-mandated Medicaid disproportionate share adjustment for all eligible hospitals, using the data and methodology described below. The Commission will use the following data sources in its determination of the federally-mandated Medicaid disproportionate share adjustment, unless the specified data source is unavailable. If the specified data source is unavailable, then the Commission will determine and use the best alternative data source.

a. The Commission will use free care charge data from the Department of Medical Security.

b. The prior year RSC-403 report will be used to determine Medicaid days, total days, Medicaid inpatient net revenues, and total inpatient charges.

c. The hospital's audited financial statements for the prior year will be used to determine the state and/or local cash subsidy.

2. The Commission will calculate a threshold Medicaid inpatient utilization rate to be used as a standard for determining the eligibility of acute care hospitals for the federally-mandated disproportionate share adjustment. The Commission will determine such threshold as follows:

a. First, calculate the statewide weighted average Medicaid inpatient utilization rate. This will be determined by dividing the sum of Medicaid inpatient days for all acute care hospitals in the state by the sum of total inpatient days for all acute care hospitals in the state.

b. Second, calculate the statewide weighted standard deviation for Medicaid inpatient utilization statistics. This will be determined according to the following formula:

$$\sqrt{\frac{\sum\left(\left(\text{average days}\right)\left(\text{total days}\right)\right) - \frac{\left(\Sigma\ \text{Medicaid days}\right)^2}{\left(\Sigma\ \text{total days}\right)}}{N}}$$

Where N = number of hospitals, and average days = statewide sum of total days, divided by the number of hospitals.

c. Third, add the statewide weighted standard deviation for Medicaid inpatient utilization to the statewide average Medicaid inpatient utilization rate. The sum of these two numbers will be the threshold Medicaid inpatient utilization rate.

d. The Commission will then calculate each hospital's Medicaid inpatient utilization rate by dividing each hospital's Medicaid inpatient days by its total inpatient days. If this hospital-specific Medicaid inpatient utilization rate equals or exceeds the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.13(10)(b)2.c., then the hospital will be eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method.

36.13: continued

3. The Commission will then calculate each hospital's low-income utilization rate as follows:

a. First, calculate the Medicaid and subsidy share of gross revenues according to the following formula:

$$\frac{\text{Medicaid gross revenues + state and local government cash subsidies}}{\text{Total revenues + state and local government cash subsidies}}$$

b. Second, calculate the free care percentage of total inpatient charges by dividing the inpatient share of free care charges less the portion of state and local government cash subsidies for inpatient services by total inpatient charges.

c. Third, compute the low-income utilization rate by adding the Medicaid and subsidy share of total revenues calculated pursuant to 114.1 CMR 36.13(10)(b)3.a. to the free care percentage of total inpatient charges calculated pursuant to 114.1 CMR 36.13(10)(b)(3)b. If the low-income utilization rate exceeds 25%, the hospital will be eligible for the federally-mandated disproportionate share adjustment under the low-income utilization rate method.

4. Additional Criteria for Eligibility:

a. The hospitals identified as eligible for federally-mandated disproportionate share adjustments must have at least two obstetricians who have staff privileges at the hospital unless:

i. the hospital has inpatients predominantly under 18 years of age; or

ii. the hospital does not offer non-emergency obstetric services to the general population as of December 22, 1987.

5. Payment Methodology. The payment under the federally-mandated disproportionate share adjustment requirement will be calculated as follows:

a. For each hospital deemed eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method established in 114.1 CMR 36.13(10)(b), the Commission will divide the hospital's Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.13(10)(b)2.d. by the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.13(10)(b)2.c. The ratio resulting from such division will be the federally-mandated Medicaid disproportionate share ratio.

b. For each hospital deemed eligible for the basic federally mandated Medicaid disproportionate share adjustment under the low-income utilization rate method, but not found to be eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method, the Commission will divide the hospital's low-income utilization rate by 25%. The ratio resulting from such division will be the federally-mandated Medicaid disproportionate share ratio.

c. The Commission will then determine, for the group of all eligible hospitals, the sum of federally-mandated Medicaid disproportionate share ratios calculated pursuant to 114.1 CMR 36.13(10)(b)5.a. and 114.1 CMR 36.13(10)(b)5.b.

d. The Commission will then calculate a minimum payment under the federally-mandated Medicaid disproportionate share adjustment requirement by dividing the amount of funds allocated pursuant to 114.1 CMR 36.13(10)(b)6. for payments under the federally-mandated Medicaid disproportionate share adjustment requirement by the sum of the federally-mandated Medicaid disproportionate share ratios calculated pursuant to 114.1 CMR 36.13(10)(b)5.c.

e. The Commission will then multiply the minimum payment under the federally-mandated Medicaid disproportionate share adjustment requirement by the federally-mandated Medicaid disproportionate share ratio established for each hospital pursuant to 114.1 CMR 36.13(10)(b)5.a. and b. The product of such multiplication will be the payment under the federally-mandated disproportionate share adjustment requirement. This payment ensures that each hospital's utilization rate exceeds one standard deviation above the mean, in accordance with 42 U.S.C. § 1396r-4.

36.13: continued

6. The total amount of funds allocated for payment to acute care hospitals under the federally-mandated Medicaid disproportionate share adjustment requirement will be $200,000 per year. These amounts will be paid by the Division of Medical Assistance, and distributed among the eligible hospitals as determined pursuant to 114.1 CMR 36.13(10)(b)5.e.

(c) Disproportionate Share Adjustment for Safety Net Providers. The Commission shall determine a disproportionate share safety net adjustment factor for all eligible hospitals, which takes into account the special circumstances of disproportionate share hospitals by adjusting Medicaid rates of payment in a manner to relieve the disproportionate burden of free care given by such hospitals.

1. Data Sources. The Commission will use free care charge data from the Department of Medical security, and total charges from the RSC-404. If the specified data source is unavailable, then the Commission shall determine and use the best alternative data source.

2. Eligibility of Federally-mandated Disproportionate Share Hospitals for the Safety Net Provider Adjustment. The disproportionate share adjustment for safety net providers is an additional payment for all hospitals eligible for the basic federally-mandated disproportionate share adjustment pursuant to 114.1 CMR 36.13(10)(b), which also meet the following additional criteria:

a. is a public hospital

b. has a volume of free care charges in FY91 which is at least 10% of its total charges.

c. is an essential safety net provider in its service area, as demonstrated by delivery of services to populations with special needs including persons with AIDS, trauma victims, high-risk neonates, and indigent patients without access to other providers

d. is in a municipality which has completed an agreement with the Division of Medical Assistance for intergovernmental transfer of funds to the Medicaid program for the federally-mandated disproportionate share adjustment for safety net providers.

3. Payment to Federally-mandated Disproportionate Share Hospitals under the Adjustment for Safety Net Providers. The Commission will calculate an additional adjustment for federally-mandated disproportionate share hospitals which are eligible for the safety net provider adjustment, pursuant to 114.1 CMR 36.13(10)(d)2. This adjustment shall be reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under Title XIX, or to low-income patients, and shall be calculated as follows:

a. The Commission shall calculate for each eligible hospital, its rate year free care percentage of charges, by dividing the hospital's total net free care charged off by its total charges.

b. The federally-mandated disproportionate share adjustment for safety net providers shall equal one plus the free care percentage of charges calculated pursuant to 114.1 CMR 36.13(10)(d)3.a.

c. The federally-mandated disproportionate share adjustment for safety net providers shall not be in effect for any rate year in which Federal Financial Participation under Title XIX is unavailable for this payment.

(d) Uncompensated Care Disproportionate Share Adjustment. Hospitals eligible for this adjustment are those that report "free care costs," as defined by regulations of the Department of Medical Security (DMS), at or above the median free care costs relative to all acute hospitals participating in the free care pool administered by the Department of Medical Security pursuant to M.G.L. c. 118F. The payment amounts for eligible hospitals are determined by the Department of Medical Security in accordance with its regulations at 117 CMR 7.00. These payments will be made to eligible hospitals in accordance with Department of Medical Security regulations, the ISA between the Division of Medical Assistance, the Department of Medical Security, and the Comptroller's Office. Eligible hospitals will receive these payments on a periodic basis during the term of their Medicaid contract with the Division.

Exhibit 5 To Inpatient State Plan

Department of Medical Security Regulations

117 CMR 7.00

OFFICIAL

117 CMR 7.00: ADMINISTRATION OF ACUTE HOSPITAL UNCOMPENSATED CARE POOL AND CRITERIA FOR CREDIT AND COLLECTION POLICIES UNDER M.G.L. c. 118F AS MOST RECENTLY AMENDED BY St. 1991, c. 495

Section

7.01: General Provisions

(1) Scope, Purpose and Effective Date.

(a) 117 CMR 7.00 implements the provisions of M.G.L. c. 118F, as most recently amended by St. 1991, c. 495, regarding the acute hospital uncompensated care pool.

(b) The purpose of 117 CMR 7.00 is to specify:

1. The rules which will govern payment by hospitals to the pool and payment by the pool to hospitals.

2. The procedures that acute care hospitals must follow regarding the acquisition and verification of patients' financial resource information for determination of patients' ability to pay for hospital care provided and/or to be provided.

3. The criteria that acute care hospitals must meet regarding notification of the availability of free care and public assistance programs to patients.

4. The criteria that acute care hospitals' credit and collection policies must meet regarding bad debt and free care accounts. This shall include, the standards for reasonable collection effort of bad debt accounts; the standards for determining free care accounts; and the standards for documenting bad debt and free care accounts.

(c) 117 CMR 7.00 shall be effective as follows:

1. definitions at 117 CMR 7.02 shall be effective beginning on October 1, 1991;

2. reporting requirements of 117 CMR 7.03 shall be effective for all claims reported for the month of April, 1992 and for all the months thereafter;

3. all other sections of 117 CMR 7.00 shall be effective upon the promulgation of 117 CMR 7.00, unless otherwise specified.

4. 117 CMR 7.02, 7.04(3)(a) and (b), 7.04(4), 7.04(5), 7.04(8) and 7.01(1)(c)(4) shall be effective as of June 4, 1993;

5. 117 CMR 7.11 shall be effective as of October 1, 1993.

(2) Authority: 117 CMR 7.00 is adopted pursuant to M.G.L. c. 118F as most recently amended by St. 1991, c. 495.

(3) Organization: 117 CMR 7.00 is divided into sections. Each section may be further divided into subsections designated by arabic numerals enclosed in parentheses. A subsection may be segregated into divisions, designated by letters enclosed in parentheses. A division may be further segregated into subdivisions designated by arabic numerals followed by a period.

7.02: Definitions

Actual Costs. All direct and indirect costs incurred by a hospital or a community health center in providing medically necessary care and treatment to its patients, in accordance with generally accepted accounting principles

7.02: continued

Bad Debt. An account receivable based on services furnished to any patient which:

(a) is regarded as uncollectible, following reasonable collection efforts, pursuant to the hospital's credit and collection policies and procedures;

(b) is charged as a credit loss pursuant to the hospital's credit and collection policies and procedures;

(c) is not the obligation of any governmental unit of the federal or state government or agency thereof; and

(d) is not free care.

Charge. The uniform price for each specific service within a revenue center of an acute hospital established in accordance with M.G.L. c. 6B, § 7.

Collection Action. Any activity by which a hospital or its designated agent requests payment for services from a patient or a patient's guarantor. A collection action of a hospital shall include those activities such as preadmission or pretreatment deposits, billing statements, collection follow-up letters telephone contacts, personal contacts and activities of collection agencies and attorneys.

Commission. The Rate Setting Commission established under M.G.L. c. 6A, § 32.

Cost to Charge Ratio. A calculation made pursuant to M.G.L. c. 6B, § 11(4), to be used by the Department of Medical Security in determining the uncompensated care pool's liability to each hospital in accordance with M.G.L. c. 118F, § 15.

Credit and Collection Policy. The hospital's policy, as expressed in a statement of general principles approved by its governing board, guiding the management of the hospital's billing and collection of accounts receivable, and the hospital's procedures, as expressed in an operating plan to implement such policy, with respect to:

(a) the effort the hospital makes to collect payment for services;

(b) the criteria the hospital uses to assign uncollectibles to bad debt account; and

(c) the criteria the hospital uses for the provision of free care. The credit and collection policy shall include, as a minimum, the methods the hospital uses, the practices it follows and the forms or schedules it adopts in order to comply with the Department's criteria and standards for credit and collection policy as set forth in 117 CMR 7.00.

Department. The Department of Medical Security established under M.G.L. c. 118F.

Disproportionate Share Hospital. Any acute hospital that exhibits a payer mix where a minimum of 63% of the acute hospital's gross patient service revenue is attributable to Title XVIII and Title XIX of the federal Social Security Act, other government payers and free care.

Emergency Aid to the Elderly, Disabled and Children (EAEDC) Patient. A patient who is a recipient of governmental benefits under M.G.L. c. 117A *et seq.*

Emergency Care. Emergency care shall include hospital services provided after sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain in which the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of a bodily organ or part, examination or treatment for emergency medical condition or active labor in women or any other service rendered to the extent required by 42 USC 1395(dd). In order to qualify as emergency care, services must be medically necessary services and must be: